16.1 INTRODUCTION

The West Virginia Medicaid Program provides payment for covered medical services to certified medical providers for eligible individuals who are aged, blind or disabled and to eligible members of families with dependent children.

The determination of which medical services are covered under Medicaid and which medical providers are certified to accept Medicaid patients is the responsibility of the Bureau for Medical Services and is not addressed in this Manual. Unless otherwise specified, the coverage group receives all services covered under Medicaid.

For eligibility for nursing care services and HCB, TBI and I/DD Waiver coverage groups, refer to Chapter 17.

This Chapter provides an overview of the Medicaid Program. In addition, each coverage group has specific requirements which must be met and procedures to follow that may not apply to other Income Maintenance programs or other Medicaid coverage groups. These are contained in this Chapter.

Certain programs, such as CDCS, I/DD, TBI and HCB Waiver, require a medical and/or other determination by a community agency or government organization other than DFA and a financial determination by an Income Maintenance Worker. When an applicant's medical eligibility for, or enrollment in these programs is pending, he must not be refused the right to apply, but must be evaluated for any or all DFA programs.

NOTE: Children determined eligible for QC or PL Medicaid remain eligible for 12 continuous months, regardless of any changes after approval, except those specified in Section 2.8.

In addition to the coverage groups described in this Chapter which make up the Medicaid Program, the Department has special procedures in place to pay for certain necessary drugs for individuals not eligible for Medicaid. See Chapter 28.

A. ASSIGNMENT OF MEDICAL SUPPORT RIGHTS

Provided they are legally able to do so, all adult Medicaid applicants and recipients must assign to the Department any rights to medical support and to payments for medical care from any third party.

When the adult receives Medicaid under any coverage group, under any case number, the assignment of medical support rights is a condition of eligibility and he must cooperate in identifying and providing information to use in pursuing third parties, unless good cause is established for not cooperating. This includes

providing accurate health insurance information at application and redetermination. See Section 4.2 for verification requirements. Good cause is determined by DFA, based on written information obtained by the Worker.

NOTE: All other adults who have the legal ability to do so, but who are not Medicaid recipients, must assign medical support rights as well.

When an otherwise eligible individual cannot legally assign his own rights, and the person legally able to do so does not cooperate, the individual remains eligible.

EXAMPLE: A mother refuses to assign benefits for herself and her children, for whom she can legally make an assignment. The mother is ineligible and the children remain eligible for Medicaid.

NOTE: Poverty-Level Pregnant Women are not penalized for failure to cooperate with this requirement until the expiration of the postpartum period.

An applicant for SSI is required to assign third-party rights to the Department as part of his application for SSI. If he refuses to assign these rights, he is ineligible for Medicaid.

B. DATA SYSTEM INTERACTION

When health insurance information is entered by BCSE, RAPIDS alert 191 “Ins. Info. Check OSCAR’S INSU”, is sent to the Worker. Since BCSE and BMS data systems do not interface, the Worker must enter the health insurance information on RAPIDS screen AFMC which will interface with BMS.

The Bureau for Medical Services must verify health insurance with the carrier before entering it in the BMS data system. The Worker is notified by RAPIDS alerts when BMS updates Third-Party Liability (TPL) information, there is an insurance carrier or policy number mismatch or the TPL information is not verified. See the RAPIDS User Guide for specific Worker actions required. If the Worker has any information which conflicts with the BMS-verified information, he must provide the information to the Third-Party Liability (TPL) Unit by e-mail or fax so that BMS can clear up any discrepancy. This insures accurate information is entered in both data systems.

C. CERTIFICATE OF COVERAGE WHEN MEDICAID COVERAGE ENDS

All Medicaid recipients who so request, must be issued a Certificate of Coverage DFA-HIP-1, when Medicaid benefits stop.

This applies to all individuals whose Medicaid benefits stopped on or after July 1, 1996. See Section 2.1.

D. CHILD SUPPORT REQUIREMENTS AND PROCEDURES

Federal law mandates that efforts be made to locate absent parents, establish paternity and obtain medical support for dependent children who receive Medicaid.

The responsible adult included in any Medicaid coverage group must cooperate with BCSE.

EXCEPTION: Recipients of TM cannot lose eligibility for failure to cooperate with BCSE. However, BCSE services must be explained and a voluntary referral made when appropriate.

When the responsible adult is not a Medicaid recipient under any coverage group, he must be informed of the availability of BCSE services and provided the opportunity to voluntarily receive services. Voluntary BCSE referrals do not sign the DFA-AP-1. There is no penalty when a voluntary referral subsequently fails to cooperate with BCSE.

The major responsibility for this effort rests with the Bureau for Child Support Enforcement (BCSE) through its staff of Legal Assistants.

In addition, the Worker has the following responsibilities:

- To provide a BCSE application, the App-1-interactive and an explanation of where the application is submitted, when the responsible adult who can legally assign rights and is not a Medicaid recipient under any coverage group, expresses an interest in voluntarily receiving services. For a child only case, no referral is made by the Worker and no change is made in the data system.

- To explain the requirements and benefits of BCSE services, including the right to claim good cause for refusal to cooperate

- To refer appropriate cases to the Legal Assistant. Referral is accomplished by data system exchange or DHS-1.

- To evaluate evidence presented if the client claims good cause

- To determine if good cause for failure to cooperate with BCSE exists

- To apply the penalty for refusal, without good cause, to cooperate or provide information about medical support to adults included in any Medicaid AG who can legally assign support rights.

- To respond to RAPIDS alert 191. See Section 16.1 for the required action.

a. The DFA-AP-1 must be completed for:

(1) Applicants

(a) AFDC Medicaid, AFDC-Related Medicaid

The DFA-AP-1 must be completed when at least one of the children under age 18 who receives Medicaid has a parent(s) who is absent due to death, desertion, divorce or paternity not established.

See Section 15.3 for exceptions.

(b) SSI and SSI-Related Medicaid

NOTE: Newborns are referred at birth, even though the parent may not be required to comply until the postpartum period ends. See Redirection of Support and Income Withholding below.

The DFA-AP-1 must be completed when there is at least one child under age 18 included in the AG who has a parent who is absent due to death, desertion, divorce or paternity not established. This includes children who receive SSI and SSI-Related Medicaid.

(2) Recipients

The DFA-AP-1 must be completed for active cases as follows:

(a) AFDC Medicaid and AFDC-Related Medicaid

The DFA-AP-1 must be completed when a 2-parent family becomes a 1-parent family.

(b) CEN and SSI-Related Medicaid

NOTE: Newborns are referred at birth, even though the parent may not be required to comply until the postpartum period ends. See Redirection of Support and Income Withholding below.

- When at least one parent of a child(ren) under age 18 who is included in the AG is absent due to death, desertion, divorce or paternity not established. This includes children who receive SSI and SSI-Related Medicaid.

- When a child under age 18 with a parent who is absent for one of the above reasons is added to the AG. This includes children who receive SSI and SSI-Related Medicaid.

See Section 15.3 for exceptions.

b. Instructions for completion:

- Complete in triplicate.

- Enter the case name and case number in the indicated spaces on the form.

- Enter a check mark in the block beside each paragraph number to indicate that the client understands the information.

- The responsible adult must sign the form. If the parent is in the home, the parent must sign the form.

- The Worker and client must sign all copies

- Distribute copies to the client and BCSE Child Support Specialist, and file one in the case record. If no referral is made, the extra copy is filed in the case record.

c. Procedure When the Client Refuses to Sign the DFA-AP-1

When the client refuses to sign the DFA-AP-1, the action taken depends upon the reason for the refusal. When the client indicates that he will not sign the DFA-AP-1 and, in doing so, indicates he will not cooperate with BCSE, the Worker must determine if good cause exists for the refusal. If good cause does exist, no BCSE action is required or taken and no penalty is applied to the client. If good cause does not exist, the Medicaid case is referred to BCSE and the penalty described in Redirection of Support and Income Withholding below is applied. The Worker must record in RAPIDS the circumstances involved in the determination of good cause.

When the client indicates that he will not sign the DFA-AP-1, but indicates that he will cooperate with BCSE after referral, the Medicaid case is referred to BCSE and no penalty is applied. The Worker must record in RAPIDS that the content and purpose of the form were explained to the client, that he refused to sign, the reason given for the refusal, that the client has indicated that he will

- Physical or emotional harm to the child for whom medical support is being sought; or

- Physical or emotional harm to the parent or other responsible adult with whom the child lives, which would reduce such person's capacity to care for the child adequately. A finding of good cause for emotional harm may only be based upon evidence of an emotional impairment that substantially affects the parent or other relative's functioning.

  In determining good cause based in whole or in part upon the anticipation of emotional harm, the Worker must consider the following:

  o The present emotional state of the individual;

  o The emotional health history of the individual;

  o The intensity and probable duration of the emotional impairment; and

  o The extent of involvement of the child in the paternity establishment or medical support activity to be undertaken.

b. When the Client Refuses to Cooperate Prior to BCSE Referral

If the client indicates to the Worker, prior to BCSE referral, that he does not intend to cooperate in BCSE activities, the Worker must determine if good cause exists for the refusal.

If good cause does exist, no BCSE action is required or taken and no penalty is applied to the client. If good cause does not exist, the Medicaid case is referred to BCSE and the penalty described in Redirection of Support and Income Withholding below is applied. The Worker must record in RAPIDS the circumstances involved in the determination of good cause.

c. When the Client Claims Good Cause for Refusal to Cooperate After BCSE Referral

A client may claim good cause for refusal to cooperate prior to or after referral to BCSE.

When the client claims good cause after the referral, the Legal Assistant refers the case back to the Worker for a determination of

- The Worker must determine if good cause exists within 45 days of the date good cause is claimed.

- If good cause is established, the case is not acted on by BCSE. However, at each redetermination, the Worker must determine if good cause still exists. If good cause no longer exists the Worker must notify the client and take appropriate action to notify BCSE.

- If good cause is not established, the Worker initiates the penalty and sends appropriate client notification. RAPIDS notifies BCSE that good cause was claimed, but not established, and that the penalty for refusal to cooperate has been applied.

5. Redirection Of Support And Income Withholding

NOTE: While there is no penalty for Medicaid recipients who refuse to redirect support payments, they must be instructed that being referred to BCSE automatically triggers income withholding, whenever there is an existing court order for support and an identifiable source of income.

When a Medicaid referral is made to BCSE, the Legal Assistant immediately implements income withholding for any child support the child may be receiving, whenever possible. This action may not be declined or terminated by the Medicaid client. Collection of support must, thereafter, be made through BCSE and distributed as non-public assistance (NPA) payments.

If the client refuses to cooperate in the establishment of paternity and in obtaining medical support, the Legal Assistant notifies the Worker. If the client has not claimed good cause, or if a claim is made and good cause is not determined, the penalty in Penalties For Failure To Cooperate below is applied.

6. Penalties For Failure To Cooperate

NOTE: A Poverty-Level pregnant woman, who fails to cooperate in securing medical support for children other than the unborn child, is not penalized until after the expiration of the 60-day postpartum period. Recipients of TM cannot lose eligibility for failure to cooperate with BCSE. However, BCSE services must be explained and a voluntary referral made when appropriate.

The penalty is as follows: